		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005405

Facility Name: HILLTOP CONVALESCENT CENTER

Address: 910 WEST POLK STREET (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: 217-345-7006 **Fax #** 217-345-6017

IDPA ID Number: 370776670001

Date of Initial License for Current Owners: 7/1/1958

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 8/1/04 to 7/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	923	29	3,500	4,452	8
9	SNF/PED					9
10	ICF	11,920	7,742		19,662	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,843	7,771	3,500	24,114	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.17%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/58

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 3,500

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/31/05 Fiscal Year: 7/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 **Report Period Beginning:** 8/1/04 **Ending:** 7/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	93,007	9,756	6,578	109,341		109,341	(1,007)	108,334			1
2	Food Purchase		95,225		95,225		95,225		95,225			2
3	Housekeeping	33,644	8,441		42,085		42,085		42,085			3
4	Laundry	22,032	7,284		29,316		29,316		29,316			4
5	Heat and Other Utilities			67,530	67,530		67,530		67,530			5
6	Maintenance	29,664	28,878	38,777	97,319		97,319	1,354	98,673			6
7	Other (specify):* UTILITY WORKERS	340			340		340		340			7
8	**TOTAL General Services**	178,687	149,584	112,885	441,156		441,156	347	441,503			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	787,263	163,529	65,143	1,015,935	(114,482)	901,453	7,505	908,958			10
10a	Therapy	30,846	2,814	181,664	215,324	(181,664)	33,660		33,660			10a
11	Activities	28,226	1,233		29,459		29,459		29,459			11
12	Social Services	37,065		4,905	41,970		41,970		41,970			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	883,400	167,576	266,112	1,317,088	(296,146)	1,020,942	7,505	1,028,447			16
	C. General Administration											
17	Administrative	57,847		13,623	71,470	1,081	72,551	36,269	108,820			17
18	Directors Fees											18
19	Professional Services			136,433	136,433		136,433	(127,727)	8,706			19
20	Dues, Fees, Subscriptions & Promotions			17,290	17,290		17,290	(10,390)	6,900			20
21	Clerical & General Office Expenses	39,626	11,076	7,052	57,754		57,754	26,588	84,342			21
22	Employee Benefits & Payroll Taxes			184,187	184,187		184,187	18,186	202,373			22
23	Inservice Training & Education			3,983	3,983		3,983	3,439	7,422			23
24	Travel and Seminar			7,391	7,391	(5,913)	1,478	563	2,041			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			83,520	83,520		83,520		83,520			26
27	Other (specify):*			49,803	49,803		49,803	(49,803)				27
28	**TOTAL General Administration**	97,473	11,076	503,282	611,831	(4,832)	606,999	(102,875)	504,124			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,159,560	328,236	882,279	2,370,075	(300,978)	2,069,097	(95,023)	1,974,074			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			25,412	25,412		25,412	(843)	24,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			32,159	32,159		32,159		32,159			33
34	Rent-Facility & Grounds							4,602	4,602			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			57,571	57,571		57,571	3,759	61,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					300,978	300,978		300,978			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			59,130	59,130	300,978	360,108		360,108			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,159,560	328,236	998,980	2,486,776		2,486,776	(91,264)	2,395,512			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,601)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(827)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,044)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,883)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,649)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,767)	27		24
25	Fund Raising, Advertising and Promotional	(10,488)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,109)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING	(1,007)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,375)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(20,889)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,889)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (91,264)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		181,664	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		7,324	10	42
43	Prescription Drugs	X		96,996	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule X-RAY	X		1,809	10	45
46	Other-Attach Schedule O2,Supp.	X		13,185	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 300,978		47

STATE OF ILLINOIS

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 8/1/04

Ending: 7/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 **Report Period Beginning:** 8/1/04 **Ending:** 7/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	253	0	0	0	0	0	0	0	0	0	253	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,649)	(122,217)	0	0	0	0	0	0	0	0	0	(127,866)	19
20	Fees, Subscriptions & Promotions	(10,488)	0	0	0	0	0	0	0	0	0	0	(10,488)	20
21	Clerical & General Office Expenses	(827)	0	0	0	0	0	0	0	0	0	0	(827)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(253)	0	0	0	0	0	0	0	0	0	(253)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(49,803)	0	0	0	0	0	0	0	0	0	0	(49,803)	27
28	**TOTAL General Administration**	(66,767)	(122,217)	0	0	0	0	0	0	0	0	0	(188,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(66,767)	(122,217)	0	0	0	0	0	0	0	0	0	(188,984)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **HILLTOP CONVALESCENT CENTER** **#** **0005405** **Report Period Beginning:** **8/1/04** **Ending:** **7/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,601)	0	0	0	0	0	0	0	0	0	0	(2,601)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,601)	0	0	0	0	0	0	0	0	0	0	(2,601)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,368)	(122,217)	0	0	0	0	0	0	0	0	0	(191,585)	45

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	78.18	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	Nursing Home Mngr	SPRINGFIELD	MANAGEMENT
DANA KLEIN KAVY	4.24	MEADOW MANOR	TAYLORVILLE			
PHILIP KLEIN	4.24	MENARD CONVALESCENT CENTER	PETERSBURG			
LISA KLEIN GILDAR	4.24	SUNRISE MANOR OF VIRDEN	VIRDEN			
DAVID & RAQUEL KLEIN	4.55					
JERRY & PAULA JENNINGS	4.55					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		19	MANAGEMENT FEE	$ 130,485	NURSING HOME MANAGERS	39.39%	$	$ (130,485)	1
2	V		VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS	39.39%	101,328	101,328	2
3	V		19	ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,268	8,268	3
4	V		24	TRAVEL	253	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(253)	4
5	V		17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		253	253	5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 130,738			$ 109,849	$ * (20,889)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					$ 16,274	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	78.18					2,085	17-7	2
3											3
4											4
5		H. RAYMOND KLEIN AND JERRY JENNINGS WERE PAID BY NURSING HOME									5
6		MANAGERS, INC., A RELATED ORGANIZATION. TOTAL COMPENSATIION									6
7		OF $10,010 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE FIVE									7
8		RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK. TOTAL									8
9		COMPENSATION OF $78,172 FOR JERRY JENNINGS WAS ALLOCATED AMONG									9
10		THE FIVE RELATED NURSING HOMES BASED UPON 35 HOURS PER WEEK.									10
11											11
12											12
13								TOTAL	$ 18,359		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC
Street Address: 2653 W. LAWRENCE, SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE WORKSHEETS				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 8/1/04 **Ending:** 7/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	50,024	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,569	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,455)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,614	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,159	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	35,172	8
	2001	29,241	9
	2002	31,126	10
	2003	31,594	11
	2004	31,951	12

LINE 2 BOTH INSTALLMENTS 2003 31,594
1ST INSTALLMENT 2004 15,975
47,569

LINE 4 2ND INSTALLMENT 2004 15,975
7/12 OF 21,951 18,639
34,614

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLTOP CONVALESCENT CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0005405

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-00706-000	HILLTOP NURSING HOME	$ 31,950.88	$ 31,950.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,950.88	$ 31,950.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1966	$ 5,295	1
2					2
3	TOTALS			$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1966		$ 253,434	$		$	$	$ 253,434	4
5	36			1972	240,043					240,043	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	2,877		10			2,877	9
10	LANDSCAPING			1980	1,417		5			1,417	10
11	IMPROVEMENT			1979	17,131		15			17,131	11
12	IMPROVEMENT			1981	4,330		VARIOUS			4,330	12
13	IMPROVEMENT			1982	3,570		15			3,570	13
14	IMPROVEMENT			1983	3,583		15			3,583	14
15	IMPROVEMENT			1984	2,461		15			2,461	15
16	IMPROVEMENT			1985	14,201		15			14,201	16
17	AIR CONDITIONER			1986	1,620	38	10		(38)	1,620	17
18	CONDENSER			1986	3,068	92	15		(92)	3,068	18
19	ROOF			1986	19,843	972	15		(972)	19,843	19
20	CUBICLE TRACKS			1987	997	32	20	50	18	949	20
21	AIR CONDITIONER			1987	1,149	36	10		(36)	1,149	21
22	AIR CONDITIONER			1988	3,145	100	10		(100)	3,145	22
23	WATER HEATER			1988	982	31	15		(31)	982	23
24	WATER HEATER			1989	2,194	70	15	51	(19)	2,193	24
25	AIR CONDITIONER			1991	1,959	62	10		(62)	1,959	25
26	SIDEWALK			1991	3,120	99	20	156	57	2,288	26
27	WIRING			1992	1,384	44	20	69	25	956	27
28	AIR CONDITIONER			1992	1,474	47	10		(47)	1,474	28
29	DOOR ALARM, FURNACE, IMPROVEMENT			1993	6,664	212	15	444	232	5,551	29
30	LANDSCAPING			1993	2,824	188	10		(188)	2,824	30
31	BLACKTOP - PER 1991 AUDIT			1990	2,186		15	146	146	1,752	31
32	AIR CONDITIONER			1994	1,613	41	10		(41)	1,613	32
33	LIGHTING			1995	2,729	70	10	136	66	2,729	33
34	AIR CONDITIONER			1996	1,112	29	8		(29)	1,112	34
35	EXHAUST FAN, FLOORING, WATER HEATERS			1996	5,048	129	15	337	208	3,199	35
36	REMODELING - WALLS			1996	1,080	28	30	36	8	324	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1996	$ 1,611	$ 41	15	$ 107	$ 66	$ 930	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	2,946	38
39	AIR CONDITIONER	1999	3,185	82	10	318	236	2,098	39
40	ROOF	1999	68,332	1,752	20	3,417	1,665	21,069	40
41	FURNACE	2000	1,273	33	15	85	52	495	41
42	AIR CONDITIONER	2001	1,404	36	10	141	105	702	42
43	GAZEBO	2001	1,374	35	15	92	57	443	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	403	44
45	FIRE DAMPERS	2002	1,451	37	15	97	60	339	45
46	FURNACE	2002	2,200	56	15	146	90	513	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	1,890	47
48	FIRE/RADIATION DAMPERS	2002	1,770	45	15	118	73	384	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	933	49
50	WATER HEATER	2004	4,320	111	15	288	177	576	50
51	FURNACE	2004	1,525	39	15	102	63	153	51
52	SIDEWALKS	2004	3,375	87	15	225	138	281	52
53	FIRE DOOR, WHEELCHAIR RAMP	2005	6,450	7	20	27	20	27	53
54	AIR CONDITIONER	2005	1,300	10	8	54	44	54	54
55	LIGHT POLES	2005	3,365	25	15	75	50	75	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 734,033	$ 5,328		$ 8,057	$ 2,729	$ 636,088	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 154,456	$ 15,183	$ 13,162	$ (2,021)		$ 84,939	71
72	Current Year Purchases	23,750	4,901	1,592	(3,309)		1,592	72
73	Fully Depreciated Assets	188,932					188,932	73
74	ASSETS NO LONGER IN SERVICE	(58,078)					(58,078)	74
75	TOTALS	$ 309,060	$ 20,084	$ 14,754	$ (5,330)		$ 217,385	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,048,388	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,811	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,601)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 853,473	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,389	$	85,839	$	1,389	$ 85,839	1
2	Licensed Speech and Language Development Therapist		hrs		80		6,749		80	6,749	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		1,923		89,076		1,923	89,076	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					96,996		96,996	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): O2, Xrays, MC Supp, Labs							22,318		22,318	13
14	TOTAL			$	3,392	$	181,664	$ 119,314	3,392	$ 300,978	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 8/1/04 **Ending:** 7/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 7/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,238	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	549,434		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,079		6
7	Other Prepaid Expenses	42,314		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 684,065	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,295		13
14	Buildings, at Historical Cost	731,847		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	365,569		16
17	Accumulated Depreciation (book methods)	(919,055)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 183,656	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 867,721	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,000	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,564		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,349		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,613		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,109		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 194,635	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 194,635	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 673,086	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 867,721	$	48

***(See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 574,144	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 574,144	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	197,942	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(99,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,942	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 673,086	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,609,707	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,609,707	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,397	6
7	Oxygen	2,449	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 69,846	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	660	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 660	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,925	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,925	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 1007, Exp Reimb 646, Adm Fee 320	1,973	28
28a	W/A 52, Old Checks 455, Bad Debt Recovery 100	607	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,580	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,684,718	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	441,156	31
32	Health Care	1,317,088	32
33	General Administration	611,831	33
	B. Capital Expense		
34	Ownership	57,571	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,486,776	40
41	**Income before Income Taxes (line 30 minus line 40)****	197,942	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 197,942	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 53,316	$ 25.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,830	6,264	123,345	19.69	3
4	Licensed Practical Nurses	13,731	14,142	207,433	14.67	4
5	CNAs & Orderlies	42,793	43,420	403,169	9.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,744	2,881	30,846	10.71	8
9	Activity Director	1,981	2,020	16,990	8.41	9
10	Activity Assistants	1,659	1,685	11,236	6.67	10
11	Social Service Workers	4,061	4,220	37,065	8.78	11
12	Dietician					12
13	Food Service Supervisor	2,100	2,211	27,062	12.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,254	9,543	65,945	6.91	15
16	Dishwashers					16
17	Maintenance Workers	3,685	3,808	29,664	7.79	17
18	Housekeepers	5,127	5,142	33,644	6.54	18
19	Laundry	2,866	3,017	22,032	7.30	19
20	Administrator	2,000	2,080	57,847	27.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,556	3,792	39,626	10.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	53	53	340	6.42	33
34	TOTAL (lines 1 - 33)	103,440	106,358	$ 1,159,560 *	$ 10.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	193	$ 6,578	1-3	35
36	Medical Director	120	14,400	9-3	36
37	Medical Records Consultant	8	280	10-3	37
38	Nurse Consultant	676	30,374	10-3	38
39	Pharmacist Consultant	96	2,700	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	83	4,905	12-3	45
46	Other(specify) Utilization Review	48	2,000	10-3	46
47	ADMINISTRATIVE CONSULTANT	420	13,623	17-3	47
48	MEDICARE CONSULTANT	192	22,639	10-3	48
49	TOTAL (lines 35 - 48)	1,836	$ 97,499		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 187	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	268	6,963	10-3	52
53	TOTAL (lines 50 - 52)	276	$ 7,150		53

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ARACELI HENSON	ADMINISTRATOR		$ 57,847
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,847

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 13,623
TOTAL (agree to Schedule V, line 17, col. 3)	$ 13,623
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 130,485
CSC	CORP. REPRESENTATION	299
FELDMAN, WASSER, ET AL	LEGAL	5,611
BRAINARD LAW OFFICE	LEGAL	38
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 136,433

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,932
Unemployment Compensation Insurance	13,390
FICA Taxes	86,160
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	3,288
EMPLOYEE CAFETERIA PLAN	51,966
EMPLOYEE VACCINES	293
HOLIDAY PARTIES	393
GIFT CERTIFICATES	765
NURSING HOME MANAGERS ALLOCATION	18,186
TOTAL (agree to Schedule V, line 22, col.8)	$ 202,373

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
EMPLOYEE VACCINES	22	$ 293
HOLIDAY PARTIES	22	393
GIFT CERTIFICATES	22	765
TOTAL		$ 1,451

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,311
Health Care Worker Background Check	1,268
(Indicate # of checks performed 79)	
PUBLIC RELATIONS	10,488
FRANCHISE FEES	163
FOOD SERVICE SANITATION	70
NURSING HOME MNGRS ALLOCATION	98
Less: Public Relations Expense	(10,488)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,900

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	1,478
LESS 31% TRANS TO ADMINISTRATIVE	(253)
NURSING HOME MNGRS ALLOCATION	816
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,041

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/04 Ending: 7/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT	9/90	$ 1,925	3 YRS	$	$	$	$	$	$	$	$	$
2	DECORATION	7/93	1,884	3 YRS									
3	PAINT & WALLCOVER	7/94	3,986	3 YRS									
4	PAINT & WALLPAPER	7/96	3,825	3 YRS									
5	PAINT & WALLPAPER	3/97	5,058	3 YRS									
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,678		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 8/1/04 **Ending:** 7/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,281** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **808**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER GENERAL ADMINISTRATION

FINES	$ 5,883
BAD DEBT	36,767
SALES TAX	4,044
ILLINOIS RT TAX	3,109
TOTAL LINE 27 - COLUMN 3	$ 49,803

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:		LINE #
OXYGEN	$ (12,307)	10
MEDICARE DRUGS	(96,996)	10
MEDICARE LAB FEES	(7,324)	10
MEDICARE SUPPLIES	(878)	10
MEDICARE X-RAYS	(1,809)	10
PHYSICAL THERAPY	(89,076)	10A
SPEECH THERAPY	(6,749)	10A
OCCUPATIONAL THERAPY	(85,839)	10A
RECLASS TO: ANCILLARY SERVICES	$ 300,978	39
RECLASS TO:		
NURSE CONSULTANT MILEAG	$ 4,832	10
ADMINISTRATIVE CONSULTANT MILEAGE	1,081	17
RECLASS FROM: TRAVEL	$ (5,913)	24

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION

ACTIVITY COURSE	$ 350
MEDICARE TRAINING	379
FOOD SANITATION COURSE	80
SAFETY SEMINAR	783
NURSING SEMINARS	785
MDS CLASS AND TRAINING	779
Q I TRAINING	300
HOME OFFICE INSERVICES	527
NURSING HOME MANAGERS ALLOCATION	3,439
SCHEDULE V - LINE 23 - COLUMN 8	$ 7,422

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	$ 22,811
NURSING HOME MANAGERS ALLOCATION	1,758
SCHEDULE V - LINE 30 - COLUMN 8	$ 24,569

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	$ 197,942
* MANAGEMENT FEE 7/31/03	(9,741)
* MANAGEMENT FEE 7/31/04	15,920
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	(1,925)
TAXABLE INCOME	$ 202,196

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

PAGE 6 SCHEDULE VII B LINE 2
NURSING HOME MANAGERS COSTS

CENTRAL OFFICE COST ALLOCATION
HILLTOP
2004

	AUG 04	SEPT	OCT	NOV	DEC	JAN 05	FEB	MARCH	APRIL	MAY	JUNE	JULY	2004 TOTAL	LINE
SALARIES-ADMIN	$2,533	$2,548	$2,553	$2,600	$2,729	$2,988	$2,977	$2,982	$2,992	$3,012	$2,906	$3,111	$33,931	17
SALARIES-CLERIC	1,905	1,916	1,920	1,956	2,053	2,145	2,138	2,141	2,148	2,162	2,086	2,234	24,805	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	734	738	739	753	790	534	533	533	535	539	520	557	7,505	10
ACCOUNTING	14	15	15	15	16	9	9	9	9	9	9	10	139	19
WORK COMP INS	19	19	19	19	20	19	19	19	19	19	19	20	230	22
SUPPLIES	84	84	84	86	90	101	101	101	101	102	98	105	1,139	21
TELEPHONE	106	107	107	109	115	132	132	132	132	133	128	137	1,471	21
EMPL BENEFITS	1,103	1,110	1,112	1,132	1,188	1,034	1,030	1,032	1,035	1,042	1,006	1,077	12,902	22
PAYROLL TAXES	328	330	330	336	353	428	426	427	428	431	416	445	4,677	22
TRAVEL	53	54	54	55	57	77	77	77	78	78	75	81	816	24
IN SERVICE	218	219	219	223	234	331	330	331	332	334	322	345	3,439	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	18	19	19	19	20	22	22	22	22	22	21	23	248	6
OWNERS COMP	158	159	159	162	171	182	181	181	182	183	177	189	2,085	17
INS-PROP,LIAB,WC	28	28	28	29	30	33	33	33	33	34	32	35	377	26
DEPRECIATION	134	134	135	137	144	153	153	153	153	154	149	159	1,758	30
RENT	338	340	341	347	365	409	408	408	409	412	398	426	4,602	34
MAINTENANCE	100	100	101	103	108	85	84	85	85	85	82	88	1,106	6
FEES & PUBLICAT	7	7	7	8	8	8	8	8	9	9	8	9	98	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$7,881	$7,928	$7,944	$8,090	$8,492	$8,691	$8,661	$8,675	$8,703	$8,761	$8,453	$9,051	$101,328	
FIXED ASSETS													101,328	
EQUIP - PRIOR	4,106	4,130	4,139	4,215	4,424	13,049	13,004	13,025	13,067	13,154	12,693	13,590	9,383	
EQUIP - CURR	2,729	2,745	3,209	3,268	3,430	0	0	102	102	103	375	402	1,372	
EQUIP - FULLY DEP	7,346	7,389	7,404	7,540	7,915	4,205	4,190	4,197	4,210	4,239	4,090	4,379	5,592	
BLDG - PRIOR	1,256	1,264	1,266	1,290	1,354	1,481	1,476	1,478	1,483	1,493	1,441	1,543	1,402	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

HILLTOP CONVALESCENT CENTER # 0005405 8/1/04 TO 7/31/05 PAGE27
MONTHLY COSTS ALLOCATIONS ON PAGE 26

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,533	$3,216	$2,366	$2,400	$3,044	$13,559
SALARIES-CLERIC	0	1,905	2,419	1,779	1,805	2,289	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	734	931	685	695	881	3,927
ACCOUNTING	0	14	18	14	14	17	78
WORK COMP INS	0	19	24	18	18	23	100
SUPPLIES	0	84	106	78	79	101	449
TELEPHONE	0	106	135	99	101	128	569
EMPL BENEFITS	0	1,103	1,401	1,030	1,045	1,325	5,904
PAYROLL TAXES	0	328	416	306	310	394	1,754
TRAVEL	0	53	68	50	50	64	285
IN SERVICE	0	218	276	203	206	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	23	17	18	22	99
OWNERS COMP	0	158	201	148	150	190	847
INS-PROP,LIAB,WC	0	28	36	26	27	34	150
DEPRECIATION	0	134	170	125	127	161	716
RENT	0	338	430	316	321	407	1,812
MAINTENANCE	0	100	127	93	95	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,881	$10,007	$7,360	$7,466	$9,469	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,106	5,214	3,835	3,890	4,934	21,978
EQUIP - CURR	0	2,729	3,465	2,548	2,585	3,278	14,605
EQUIP - FULLY DEP	0	7,346	9,328	6,861	6,959	8,826	39,320
BLDG - PRIOR	0	1,256	1,595	1,173	1,190	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
SALARIES-ADMIN	$0	$2,548	$3,086	$2,392	$2,492	$3,041	$13,559
SALARIES-CLERIC	0	1,916	2,321	1,799	1,874	2,287	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	738	894	693	722	881	3,927
ACCOUNTING	0	15	18	14	14	17	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	102	79	82	101	449
TELEPHONE	0	107	130	100	105	128	569
EMPL BENEFITS	0	1,110	1,344	1,042	1,085	1,324	5,904
PAYROLL TAXES	0	330	399	309	322	393	1,754
TRAVEL	0	54	65	50	52	64	285
IN SERVICE	0	219	265	206	214	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	22	99
OWNERS COMP	0	159	193	149	156	190	847
INS-PROP,LIAB,WC	0	28	34	27	28	34	150
DEPRECIATION	0	134	163	126	132	160	716
RENT	0	340	412	320	333	406	1,812
MAINTENANCE	0	100	122	94	98	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,928	$9,601	$7,443	$7,753	$9,461	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,130	5,002	3,878	4,039	4,929	21,978
EQUIP - CURR	0	2,745	3,324	2,577	2,684	3,275	14,605
EQUIP - FULLY DEP	0	7,389	8,949	6,937	7,226	8,818	39,320
BLDG - PRIOR	0	1,264	1,530	1,187	1,236	1,508	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
SALARIES-ADMIN	$0	$2,553	$3,116	$2,363	$2,408	$3,118	$13,559
SALARIES-CLERIC	0	1,920	2,343	1,778	1,811	2,345	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	739	902	684	697	903	3,927
ACCOUNTING	0	15	18	14	14	18	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	103	78	80	103	449
TELEPHONE	0	107	131	99	101	131	569
EMPL BENEFITS	0	1,112	1,357	1,029	1,048	1,358	5,904
PAYROLL TAXES	0	330	403	306	311	403	1,754
TRAVEL	0	54	66	50	51	66	285
IN SERVICE	0	219	268	203	207	268	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	23	99
OWNERS COMP	0	159	195	148	150	195	847
INS-PROP,LIAB,WC	0	28	35	26	27	35	150
DEPRECIATION	0	135	164	125	127	165	716
RENT	0	341	416	316	322	417	1,812
MAINTENANCE	0	101	123	93	95	123	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,944	$9,694	$7,353	$7,491	$9,702	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,139	5,051	3,831	3,903	5,055	21,978
EQUIP - CURR	0	3,209	3,916	2,970	3,026	3,919	17,041
EQUIP - FULLY DEP	0	7,404	9,036	6,854	6,983	9,044	39,320
BLDG - PRIOR	0	1,266	1,545	1,172	1,194	1,547	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
SALARIES-ADMIN	$0	$2,600	$3,195	$2,337	$2,390	$3,038	$13,559
SALARIES-CLERIC	0	1,956	2,403	1,757	1,798	2,285	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	753	925	677	692	880	3,927
ACCOUNTING	0	15	18	13	14	17	78
WORK COMP INS	0	19	24	17	18	22	100
SUPPLIES	0	86	106	77	79	100	449
TELEPHONE	0	109	134	98	100	128	569
EMPL BENEFITS	0	1,132	1,391	1,017	1,041	1,323	5,904
PAYROLL TAXES	0	336	413	302	309	393	1,754
TRAVEL	0	55	67	49	50	64	285
IN SERVICE	0	223	274	201	205	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	17	22	99
OWNERS COMP	0	162	200	146	149	190	847
INS-PROP,LIAB,WC	0	29	35	26	26	34	150
DEPRECIATION	0	137	169	123	126	160	716
RENT	0	347	427	312	319	406	1,812
MAINTENANCE	0	103	126	92	94	120	535
FEES & PUBLIC	0	8	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,090	$9,939	$7,270	$7,436	$9,450	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,215	5,178	3,788	3,874	4,924	21,978
EQUIP - CURR	0	3,268	4,015	2,937	3,004	3,818	17,041
EQUIP - FULLY DEP	0	7,540	9,264	6,776	6,931	8,809	39,320
BLDG - PRIOR	0	1,290	1,584	1,159	1,185	1,507	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%
SALARIES-ADMIN	$0	$2,729	$3,295	$2,374	$2,240	$2,921	$13,559
SALARIES-CLERIC	0	2,053	2,478	1,786	1,685	2,197	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	790	954	688	649	846	3,927
ACCOUNTING	0	16	19	14	13	17	78
WORK COMP INS	0	20	24	18	17	22	100
SUPPLIES	0	90	109	79	74	97	449
TELEPHONE	0	115	138	100	94	123	569
EMPL BENEFITS	0	1,188	1,435	1,034	975	1,272	5,904
PAYROLL TAXES	0	353	426	307	290	378	1,754
TRAVEL	0	57	69	50	47	61	285
IN SERVICE	0	234	283	204	192	251	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	20	24	17	16	21	99
OWNERS COMP	0	171	206	148	140	182	847
INS-PROP,LIAB,WC	0	30	36	26	25	32	150
DEPRECIATION	0	144	174	125	118	154	716
RENT	0	365	440	317	299	390	1,812
MAINTENANCE	0	108	130	94	88	115	535
FEES & PUBLIC	0	8	10	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,492	$10,251	$7,387	$6,969	$9,087	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,424	5,341	3,848	3,631	4,734	21,978
EQUIP - CURR	0	3,430	4,141	2,984	2,815	3,671	17,041
EQUIP - FULLY DEP	0	7,915	9,555	6,885	6,496	8,470	39,320
BLDG - PRIOR	0	1,354	1,634	1,178	1,111	1,449	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
SALARIES-ADMIN	$0	$2,988	$3,348	$2,336	$2,253	$2,639	$13,564
SALARIES-CLERIC	0	2,145	2,404	1,678	1,618	1,895	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	534	599	418	403	472	$2,426
ACCOUNTING	0	9	10	7	7	8	$42
WORK COMP INS	0	19	21	15	14	17	$87
SUPPLIES	0	101	113	79	76	89	$459
TELEPHONE	0	132	148	103	100	117	$599
EMPL BENEFITS	0	1,034	1,159	809	780	913	$4,695
PAYROLL TAXES	0	428	479	334	322	378	$1,941
TRAVEL	0	77	87	61	58	68	$352
IN SERVICE	0	331	371	259	250	293	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	24	17	16	19	$99
OWNERS COMP	0	182	204	142	137	161	$825
INS-PROP,LIAB,WC	0	33	37	26	25	29	$151
DEPRECIATION	0	153	172	120	115	135	$695
RENT	0	409	458	320	308	361	$1,857
MAINTENANCE	0	85	95	66	64	75	$385
FEES & PUBLIC	0	8	10	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,691	$9,739	$6,797	$6,555	$7,678	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,049	14,623	10,205	9,842	11,528	59,248
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	4,205	4,712	3,288	3,171	3,714	19,091
BLDG - PRIOR	0	1,481	1,660	1,158	1,117	1,308	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
SALARIES-ADMIN	$0	$2,977	$3,412	$2,284	$2,213	$2,678	$13,564
SALARIES-CLERIC	0	2,138	2,450	1,640	1,589	1,923	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	533	610	409	396	479	$2,426
ACCOUNTING	0	9	11	7	7	8	$42
WORK COMP INS	0	19	22	15	14	17	$87
SUPPLIES	0	101	116	77	75	91	$459
TELEPHONE	0	132	151	101	98	118	$599
EMPL BENEFITS	0	1,030	1,181	791	766	927	$4,695
PAYROLL TAXES	0	426	488	327	317	383	$1,941
TRAVEL	0	77	88	59	57	69	$352
IN SERVICE	0	330	378	253	245	297	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	25	17	16	20	$99
OWNERS COMP	0	181	208	139	135	163	$825
INS-PROP,LIAB,WC	0	33	38	25	25	30	$151
DEPRECIATION	0	153	175	117	113	137	$695
RENT	0	408	467	313	303	367	$1,857
MAINTENANCE	0	84	97	65	63	76	$385
FEES & PUBLIC	0	8	10	6	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,661	$9,927	$6,645	$6,437	$7,790	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,004	14,905	9,978	9,665	11,696	59,248
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	4,190	4,803	3,215	3,114	3,769	19,091
BLDG - PRIOR	0	1,476	1,692	1,133	1,097	1,328	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
SALARIES-ADMIN	$0	$2,982	$3,326	$2,342	$2,277	$2,637	$13,564
SALARIES-CLERIC	0	2,141	2,388	1,681	1,635	1,894	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	533	595	419	407	472	$2,426
ACCOUNTING	0	9	10	7	7	8	$42
WORK COMP INS	0	19	21	15	15	17	$87
SUPPLIES	0	101	113	79	77	89	$459
TELEPHONE	0	132	147	103	101	117	$599
EMPL BENEFITS	0	1,032	1,151	811	788	913	$4,695
PAYROLL TAXES	0	427	476	335	326	377	$1,941
TRAVEL	0	77	86	61	59	68	$352
IN SERVICE	0	331	369	260	252	292	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	24	17	17	19	$99
OWNERS COMP	0	181	202	142	138	160	$825
INS-PROP,LIAB,WC	0	33	37	26	25	29	$151
DEPRECIATION	0	153	170	120	117	135	$695
RENT	0	408	455	321	312	361	$1,857
MAINTENANCE	0	85	94	66	65	75	$385
FEES & PUBLIC	0	8	9	7	6	7	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,675	$9,677	$6,813	$6,623	$7,673	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,025	14,529	10,229	9,945	11,520	59,248
EQUIP - CURR	0	102	114	80	78	90	463
EQUIP - FULLY DEP	0	4,197	4,682	3,296	3,204	3,712	19,091
BLDG - PRIOR	0	1,478	1,649	1,161	1,129	1,308	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
SALARIES-ADMIN	$0	$2,992	$3,178	$2,287	$2,247	$2,861	$13,564
SALARIES-CLERIC	0	2,148	2,282	1,642	1,613	2,054	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	535	568	409	402	512	$2,426
ACCOUNTING	0	9	10	7	7	9	$42
WORK COMP INS	0	19	20	15	14	18	$87
SUPPLIES	0	101	108	77	76	97	$459
TELEPHONE	0	132	140	101	99	126	$599
EMPL BENEFITS	0	1,035	1,100	792	778	990	$4,695
PAYROLL TAXES	0	428	455	327	322	409	$1,941
TRAVEL	0	78	82	59	58	74	$352
IN SERVICE	0	332	352	254	249	317	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	23	17	16	21	$99
OWNERS COMP	0	182	193	139	137	174	$825
INS-PROP,LIAB,WC	0	33	35	26	25	32	$151
DEPRECIATION	0	153	163	117	115	147	$695
RENT	0	409	435	313	308	392	$1,857
MAINTENANCE	0	85	90	65	64	81	$385
FEES & PUBLIC	0	9	9	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,703	$9,245	$6,653	$6,536	$8,323	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,067	13,881	9,990	9,814	12,496	59,248
EQUIP - CURR	0	102	108	78	77	98	463
EQUIP - FULLY DEP	0	4,210	4,473	3,219	3,162	4,027	19,091
BLDG - PRIOR	0	1,483	1,576	1,134	1,114	1,418	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
SALARIES-ADMIN	$0	$3,012	$3,065	$2,379	$2,156	$2,953	$13,564
SALARIES-CLERIC	0	2,162	2,201	1,708	1,548	2,120	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	539	548	426	386	528	$2,426
ACCOUNTING	0	9	10	7	7	9	$42
WORK COMP INS	0	19	20	15	14	19	$87
SUPPLIES	0	102	104	81	73	100	$459
TELEPHONE	0	133	135	105	95	130	$599
EMPL BENEFITS	0	1,042	1,061	823	746	1,022	$4,695
PAYROLL TAXES	0	431	439	340	309	423	$1,941
TRAVEL	0	78	79	62	56	77	$352
IN SERVICE	0	334	340	264	239	327	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	22	17	16	22	$99
OWNERS COMP	0	183	186	145	131	180	$825
INS-PROP,LIAB,WC	0	34	34	27	24	33	$151
DEPRECIATION	0	154	157	122	110	151	$695
RENT	0	412	420	326	295	404	$1,857
MAINTENANCE	0	85	87	67	61	84	$385
FEES & PUBLIC	0	9	9	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,761	$8,916	$6,921	$6,273	$8,589	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,154	13,387	10,392	9,418	12,897	59,248
EQUIP - CURR	0	103	105	81	74	101	463
EQUIP - FULLY DEP	0	4,239	4,313	3,348	3,035	4,156	19,091
BLDG - PRIOR	0	1,493	1,519	1,180	1,069	1,464	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
SALARIES-ADMIN	$0	$2,906	$3,096	$2,509	$2,098	$2,955	$13,564
SALARIES-CLERIC	0	2,086	2,223	1,802	1,506	2,122	9,739
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	520	554	449	375	529	2,426
ACCOUNTING	0	9	10	8	7	9	42
WORK COMP INS	0	19	20	16	13	19	87
SUPPLIES	0	98	105	85	71	100	459
TELEPHONE	0	128	137	111	93	131	599
EMPL BENEFITS	0	1,006	1,071	868	726	1,023	4,695
PAYROLL TAXES	0	416	443	359	300	423	1,941
TRAVEL	0	75	80	65	54	77	352
IN SERVICE	0	322	343	278	233	328	1,504
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	21	23	18	15	22	99
OWNERS COMP	0	177	188	153	128	180	825
INS-PROP,LIAB,WC	0	32	35	28	23	33	151
DEPRECIATION	0	149	159	129	107	151	695
RENT	0	398	424	343	287	405	1,857
MAINTENANCE	0	82	88	71	60	84	385
FEES & PUBLIC	0	8	9	7	6	8	39
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,453	$9,006	$7,300	$6,103	$8,597	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	12,693	13,523	10,961	9,163	12,908	59,248
EQUIP - CURR	0	375	400	324	271	381	1,751
EQUIP - FULLY DEP	0	4,090	4,357	3,532	2,953	4,159	19,091
BLDG - PRIOR	0	1,441	1,535	1,244	1,040	1,465	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%
SALARIES-ADMIN	$0	$3,111	$2,976	$2,616	$1,932	$2,929	$13,564
SALARIES-CLERIC	0	2,234	2,137	1,878	1,387	2,103	9,739
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	557	532	468	346	524	2,426
ACCOUNTING	0	10	9	8	6	9	42
WORK COMP INS	0	20	19	17	12	19	87
SUPPLIES	0	105	101	89	65	99	459
TELEPHONE	0	137	131	116	85	129	599
EMPL BENEFITS	0	1,077	1,030	905	669	1,014	4,695
PAYROLL TAXES	0	445	426	374	276	419	1,941
TRAVEL	0	81	77	68	50	76	352
IN SERVICE	0	345	330	290	214	325	1,504
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	23	22	19	14	21	99
OWNERS COMP	0	189	181	159	117	178	825
INS-PROP,LIAB,WC	0	35	33	29	22	33	151
DEPRECIATION	0	159	152	134	99	150	695
RENT	0	426	407	358	264	401	1,857
MAINTENANCE	0	88	84	74	55	83	385
FEES & PUBLIC	0	9	8	7	5	8	39
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$9,051	$8,658	$7,611	$5,619	$8,521	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,590	12,999	11,427	8,437	12,794	59,248
EQUIP - CURR	0	402	384	338	249	378	1,751
EQUIP - FULLY DEP	0	4,379	4,189	3,682	2,719	4,123	19,091
BLDG - PRIOR	0	1,543	1,476	1,297	958	1,452	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON PAGE 27

OCCUPIED

DAYS 2004	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST		1,861	2,363	1,738		1,763	2,236	9,961
SEPTEM		1,815	2,198	1,704		1,775	2,166	9,658
OCTOBER		1,897	2,315	1,756		1,789	2,317	10,074
NOVEMBER		1,855	2,279	1,667		1,705	2,167	9,673
DECEMBER		2,013	2,430	1,751		1,652	2,154	10,000
TOTAL	0	22,641	28,658	20,264	0	19,099	25,789	116,451
								116,451

OCCUPIED

DAYS 2005	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	0	14,667	15,684	11,711	0	10,629	13,729	66,420
								66,420

ALLOCATION

PERCENTAGE 2004	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
AUGUST	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SEPTEMBER	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
OCTOBER	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
NOVEMBER	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
DECEMBER	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%

ALLOCATION

PERCENTAGE 2005	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%